PRINTED: 07/06/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS155AGC** 06/30/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **7560 SILVER LEAF WAY MORNING STAR CARE HOME** LAS VEGAS, NV 89147 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 6/30/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness. The census at the time of the survey was seven. Seven resident files were reviewed and six employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of D. The following deficiencies were identified: Y 072 Y 072 449.196(3) Qualications of Caregiver-Med SS=F Training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

medication or dietary supplement, the caregiver

(a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training

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This Regulation is not met as evidenced by: Based on record review on 6/30/09, the facility failed to ensure 4 of 6 caregivers complied with NAC 441A.375 regarding tuberculosis testing (Employee #3) and pre-employment physical examinations (Employee #2, #3, #4 and #5)

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NVS155AGC				B. WING		06/30/2009				
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		<u></u>			
MORNING	STAR CARE HOME			SILVER LEAF WAY VEGAS, NV 89147						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI			ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		ULD BE	(X5) COMPLETE DATE			
Y 103	Continued From page		Y 103							
	This was a repeat deficiency from the 4/16/08 State Licensure survey.									
	Severity: 2 Scope: 3									
Y 105 SS=E	449.200(1)(f) Personnel File - Background Check			Y 105						
	NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive.									
	This Regulation is not met as evidenced by: Based on record review on 6/30/09, the facility failed to ensure 2 of 6 caregivers had 2 sets of fingerprints or results from the state repository on file (Employee #2 and #3). This is a repeat deficiency from the 4/16/08 State Licensure Survey. Severity: 2 Scope: 1									
Y 252 SS=D	449.217(3) Storage o Packaging	f Food-Adequate stora	ge;	Y 252						
		nust be available for all for cooking and storing ust be appropriately								

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designated as representative payee (Resident

Scope: 3

#2).

Severity: 2

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the

resident's physician.

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by: Based on record review and interview on 6/30/09, the facility failed to obtain physician orders to administer over-the-counter (OTC) medications

to 4 of 7 residents (Resident #1,

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NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE					
MORNING STAR CARE HOME				7560 SILVER LEAF WAY LAS VEGAS, NV 89147						
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC' REGULATORY OR I		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE						
Y 877	Continued From page	e 6		Y 877						
	#3, #4 and #7).									
	Severity: 1 Scope: 3									
Y 878 SS=E	449.2742(6)(a)(1) Me	r	Y 878							
	NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescrib the physician. If a physician orders a change the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting administration of the medication shall: (1) Comply with the order.		e in							
	Based on record revie the facility failed to er	ot met as evidenced by: ew and interview on 6/3 nsure 3 of 7 residents as prescribed (Reside	30/09,							
	Severity: 2	Scope: 2								
Y 921 SS=F	449.2748(2) Medication Storage			Y 921						
33 - F	NAC 449.2748 2. Medication stored in a refrigerator, including without limitation, any over-the-counter medication, must be kept in a locked box unless									

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by: Based on observation and interview on 6/30/09, the facility failed to keep medications belonging to

7 of 7 residents in their original container (Resident #1, #2, #3, #4, #5, #6 and

Scope: 3

#7).

Severity: 2

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